WAIMEA SMILES

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Kamuela, Hawaii 96743
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Welcome to Our Practice

Taking care of our patients is our main priority. We take pride in our ability to provide you with high quality dental care designed for your unique needs and desires. The focus of our practice is health-centered, preventative dentistry. We enjoy helping our patients actively participate in their own health care and control the causes of dental disease. Further, we emphasize comprehensive treatment designed for long-term health and function.

Our staff members are devoted to making your appointments as pleasant and enjoyable as possible. We will reserve time in our schedule just for you. As a courtesy, we will send you reminders and we ask that you return that courtesy with a response. If you are unable to make an appointment, we do ask for an advance notice of at least 2 full business days, so that we may offer the reserved time to another patient. Except in the case of an emergency or illness, there will be a $75 charge for all appointments rescheduled in less than 2 full business days of your reserved time.

Hygiene appointments are not just cleanings, they are clinical appointments to assess the current condition of your oral health. At each of these visits our personable and highly skilled doctor and hygienists assess your home care and dietary habits, complete gum and tooth health diagnostics and perform an oral cancer screening. Frequency of your hygiene appointments will be established by your overall gum health.

We understand patient concerns on the safety of dental x-rays. They are necessary diagnostic tools to visualize cavities and conditions between and at the root of teeth. We limit the amount of radiation to our patients by utilizing digital imaging, lead aprons and the ALARA (as low as reasonably achievable) principle. X-ray frequency is determined by each patient's current dental condition, restorative history and risk for cavities.

I have read and agree to the Waimea Smiles Practice Policy.

Signature _____ Date _____ By _____

Patient Name _____ Relationship _____

Release of Information/Dental Benefits Assignment/Financial Agreement

The primary goal of our dental practice is to provide the highest quality oral health care in the most gentle and efficient manner. Since our practice is also a business with obligations that must be met, we ask that all patients pay for their treatment on the day of each visit unless prior arrangements have been made.

RELEASE OF INFORMATION: I authorize Waimea Smiles, 1) to perform diagnostic procedures and treatment as may be necessary for proper dental care. 2) I authorize release of any information concerning my (or my Child's) health care, advice and treatment to another dentist or health care provider.

DENTAL BENEFITS ASSIGNMENT: I authorize release of any information concerning my (or my child) health care, advice and treatment provided for the purpose of evaluating and preparation of dental claims. All benefit payments will be sent directly to me or the subscriber of my dental plan. I understand that I will need to inform Waimea Smiles Inc. of any changes in my insurance coverage, delays in payment or requests for more information from my dental plan.

FINANCIAL AGREEMENT: I understand I am financially responsible for payments in full of all accounts. I agree to pay the full amount of treatment costs at the time of service. I understand that my dental carrier or payor of my dental benefits may pay less than the actual bill for services. By signing this statement, I revoke all previous agreements to the contrary. I also understand that there will be a $25.00 service fee assessed for any returned checks. Balances not paid in full after 60 days, will incur a monthly fee of 8.4%.

I certify that I am the patient or am duly authorized by the patient as the patient's agent to execute this document and to accept its terms.

_____	_____	_____
Signature	Date	Relationship, if other than patient

PATIENT'S
NAME _____
Last First

IF CHILD
PARENT'S NAME _____
Last First

PREFERRED
NAME _____

MALE ☐ FEMALE ☐

Single ☐ Married ☐ Separated ☐

Divorced ☐ Widowed ☐ Minor ☐

CONTACT INFORMATION

MAILING
ADDRESS _____

CITY _____ STATE _____

ZIP _____

TELEPHONE
RESIDENCE:_____

BUSINESS: _____

CELL: _____
Please indicate best number to reach you at:
☐ RES. ☐ BUS. ☐ CELL

EMAIL:_____

Would you like to receive reminders via email or text message? (Check all that apply)

EMAIL ☐ TEXT ☐

I authorize Waimea Smiles Inc to contact me on my cellphone regarding my account and insurance information _____ (initials)

DATE _____ DATE OF BIRTH_____

PATIENT/PARENT
EMPLOYED BY_____

PRESENT POSITION _____

HOW LONG _____

GUARANTOR
FOR ACCOUNT _____

DRIVER'S LICENSE
NO. _____

OTHER FAMILY MEMBERS
IN THIS PRACTICE _____

_____

HOW DID YOU HEAR ABOUT US?

☐ REFERRED BY WHOM? _____
☐ INTERNET (Google, Website, Facebook, Yelp, etc.)
☐ HDS or Delta

EMERGENCY CONTACT _____

PHONE_____

PRIMARY DENTAL BENEFIT PLAN

YES ☐ NO ☐

Subscriber's Name _____
Subscriber's Date of Birth _____

SECONDARY DENTAL BENEFIT PLAN

YES ☐ NO ☐

Subscriber's Name _____
Subscriber's Date of Birth _____

CHILD DENTAL MEDICAL HISTORY

PATIENT NAME _____ _____
Last First Initial Date of Birth

CIRCLE APPROPRIATE ANSWER (Leave blank if you do not understand the question)

DENTAL HISTORY

1. YES NO Is this your child's first visit to a dentist? (If Yes, go to question 5)
2. If not, how long since last visit to the dentist?_____
3. Name of previous dentist
_____
4. YES NO Were any x-rays taken previously?
5. YES NO Does your child eat between meals?
6. YES NO Does your child eat sweets, such as candy, soda pop, chewing gum?
7. When does your child brush his/her teeth? (please circle)
Upon arising After eating Before going to bed
8. YES NO Does your child receive fluoride? (if yes, please circle how)
Fluoride Supplements with or without vitamins Fluoride treatments Toothpaste
9. YES NO Have any cavities been noted in the past?
10. YES NO Were any teeth (baby or permanent) removed by extraction?
Was it suggested that the space be maintained? YES NO
Was an appliance placed? YES NO
11. YES NO Have there been any injuries to teeth, such as falls, blows, chips, etc?
If so, describe_____
12. YES NO Has your child had any problem with dental treatment in the past?
13. YES NO Has anyone in the family, including parents, had orthodontics?
14. YES NO Has your child ever received a local anesthetic?
15. YES NO Has your child ever had occlusal sealants?
16. YES NO Does your <u>child</u> think there is anything wrong with his/her teeth?

MEDICAL HISTORY

1. YES NO Does your child have a health problem?
If YES, explain _____
2. YES NO Is your child under the care of a physician?
If YES, explain_____
3. **Name of Physician** **Phone**
_____
4. YES NO Is your child receiving medication?
If YES, please list_____

5. YES NO Is your child allergic to penicillin, antibiotics or other drugs?
If YES, please list_____

6. YES NO Is your child allergic or sensitive to latex?

7. YES NO Does your child have other allergies?

8. YES NO Has your child had any serious illness?
When?_____ What?_____

9. YES NO Has your child ever had surgery?

10. YES NO Does your child have a heart murmur?

11. YES NO Is surgery contemplated?

12. YES NO Does your child experience severe or prolongated bleeding?

13. YES NO Does your child have AIDS or has he/she tested HIV positive?

14. YES NO Has your child tested positive for hepatitis?

15. YES NO Is your child subject to nervous disorders?
If YES, Please list_____

16. YES NO Does your child have frequent headaches? _____

17. YES NO Has your child had a history of: (circle appropriate responses) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

There are several socially influenced activities that increase the risk for oral and oropharyngeal cancer. In our efforts to promote oral health and cancer prevention, we want to educate all of our patients on these risk factors.

Please check all of the cancer risk factor topics that you prefer we **NOT discuss** with your adolescent.

☐ Human Papilloma Virus (HPV) ☐ E-Cigarettes / Vaping ☐ Chewing Tobacco

☐ Bulimia ☐ Marijuana

☐ Smoking ☐ Alcohol

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my child's physician.

Parent or Guardian's Signature _____ Date _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my child's health and/or medication. Further, I will not hold my dentist, or any other member of her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient (Parent or Guardian) Date Signature of Dentist Date

How Your Health Information May Be Used

To Obtain Payment

We may include your health information to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically.

To Provide Treatment

We will use your Health Information within our office to provide you with the best dental care possible. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business office staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing you treatment.

For Law Enforcement

As permitted or required by State or Federal Law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with persons you authorize. In the case of an emergency, we will use our very best judgement when sharing your health information.

Authorization to Use or Disclose Health Information

Other than is stated above or where Federal, State or Local law requires us, we will not disclose your health information other than with your written authorization. You may revoke the authorization in writing at any time.

To Conduct Health Care Operations

Your health information may be reviewed for staff training, insurance audits or the routine processes of certification, licensing or credentialing activities.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security.

In Patient Reminders

We believe regular care is very important and will contact you via postcard, letter, email, telephone or fax to remind of scheduled appointments, recalls or follow-up care. You have the right to request we contact you in a certain way.

Abuse or Neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect or domestic violence.

Patient Rights

Confidential Communications

You have the right to request restrictions on certain uses and disclosures of your health information. You have the right to request we communicate with you in a certain way, i.e. mail, telephone, etc. We will honor reasonable requests.

Inspect and Copy Your Health Information

You have the right to read, review and copy your health information. Charges may apply.

Amend Your Health Information

You have the right to ask us to update or modify your records if you feel they are incorrect or incomplete. Requests must be made in writing and may be denied.

Documentation of Health Information

You have the right to ask us for a description of when your health information was used for purposes other than treatment, payment or other health care operations. A fee may apply.

Request a Paper Copy of this Notice

Our office is required to give you a copy of our Privacy Practices.

WAIMEA SMILES
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____ _____
{Signature} {Date}

In addition to allowable disclosures described in the notice of privacy practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

Any member of my immediate family __Yes __No
Spouse Only __ Yes __No
Other: (please specify)_____

I understand that I can revoke these additional authorizations at any time by calling 887-8801 or emailing the office at info@waimeasmiles.com.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (please specify)

E-MAIL WAIVER

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) sets standards for protecting the rights of individuals (patients). Waimea Smiles Inc. follows the laws that grant every individual the right to privacy and confidentiality of their personal and health information. To comply with HIPAA regulations, e-mail correspondence that contains protected personal and health information must be sent encrypted (secured). Each time you receive an encrypted message from our office, you will need to obtain a one-time password to open the message. Instructions are sent with the encrypted message. If you wish to have unencrypted (un-secure) e-mail sent to you for the sake of your convenience, you must sign the following waiver:

I, _____ request that, for my convenience, Waimea Smiles Inc. correspond with me by unencrypted (unsecure) e-mail. I understand that e-mails sent to me may contain personal and/or protected health information. I further understand that unencrypted e-mail and e-mail attachments are not secure and may be viewed by others. I agree to hold harmless Waimea Smiles Inc., its officers, agents, employees and contract health providers from any and all liability, loss, damages, costs, or expenses which are sustained, incurred, or required arising from the transmission of unencrypted (unsecure) e-mail correspondence and attachments.

I hereby direct Waimea Smiles Inc. to send all emails in an unencrypted (unsecure) format to this address:

This waiver will remain in force until revoked in writing. It may revoked in writing at any time

Signed and dated _____

_____